University Orthopedic and Joint Replacement Center
Richard D. Berkowitz, M.D., FAAOS
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TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively through electronic means. Telephone consultations, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all examples of telehealth services.

Patient initials

_____ Telehealth involves communication of my medical information in an electronic or technology-assisted format. By signing below, I understand there are inherent risks of errors/deficiencies in the electronic transmission of health information and images during a telehealth visit.

_____ I understand that electronic communication cannot be used for emergencies, urgent requests or time-sensitive matters.

_____ I understand that I may opt out of telehealth visits at any time and this will not change my ability to receive future care at this office.

_____ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment are reduced, risks still exist and include but are not limited to:

- Electronic communication can be intercepted, forwarded or even changed without my knowledge, despite taking all reasonable precautions
- Electronic systems accessed by employers, friends, or others are not secure and should be avoided. I should use a secure network
- Despite reasonable efforts by my healthcare provider, transmission of medical information could be disrupted or distorted by technical failures

_____ My healthcare provider is not responsible for breaches of confidentiality caused by independent third parties or by me.

_____ I understand and agree that medical evaluations via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. I agree to accept responsibility for following my provider's recommendations including further diagnostic testing such as lab tests, radiologic exams or in-office visits.

_____ I understand there is never a warranty or guarantee of a particular result or outcome related to a condition or diagnosis when medical care is provided.

_____ I understand that telehealth billing information is collected in the same manner as a regular office visit and my financial responsibility will be determined by my insurance plan. It is my responsibility to check with my insurance plan to determine coverage.

_____ To the extent permitted by law, I agree to waive and release my healthcare provider and his/her practice from any claims I may have about the telehealth visit.

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I certify that I have read and understand this telehealth informed consent and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.

Patient/legal representative signature_____ Date_____

Print Patient/legal representative name_____